COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS CLAIMS
CLAIM NO. _____
BEFORE _____

_____ PLAINTIFF
(EMPLOYEE)

VS. **MOTION TO REOPEN**
BY EMPLOYEE

_____ DEFENDANT(S)
(EMPLOYER)

_____
(INSURANCE CARRIER)

_____
(**OTHER DEFENDANTS, IF APPLICABLE)**

_____
(**SPECIAL FUND, IF APPLICABLE)**

****

The undersigned moves to reopen this claim based on the following grounds **(check all that apply)**:

__ Change of disability shown by objective medical evidence
__ Fraud
__ Mistake
__ Newly discovered evidence
__ Medical dispute
__ Conforming the award to employees work status for injuries after 12-12-96.
__ Reducing a permanent total disability award when employee returns to work.

Explanation:

_____

_____

_____

_____

The undersigned further states that the following information is correct **(check appropriate response)**:

1. __ No previous motion to reopen has been filed.

   __ Previous motion to reopen filed
   Month Day Year

On medical disputes:

2. __ Utilization review was done on _____. A copy of the decision is attached.
   (DATE)

   __ Utilization review is not required because

This motion is supported by the following attached documents:

1. Affidavit(s) of _____
   (EMPLOYEE, OTHER WITNESS NAMES)

2. Medical report of _____
   (DOCTOR'S NAME)

3. A current medical release Form 106 signed and witnessed.

4. A copy of the Opinion and Award, Settlement, Agreed Order, or Agreed Resolution sought to be reopened.

The undersigned, being duly sworn, states the foregoing statements in this motion and in Form 106 are true and accurate to the best of my knowledge and belief.

This the _____ day of _____ 20____.

_____

(EMPLOYEE'S SIGNATURE)

Subscribed and sworn to before me this _____ day of _____ 20____.

_____

NOTARY PUBLIC

My Commission expires: _____ County: _____

Respectfully submitted,

_____

(EMPLOYEE'S SIGNATURE)

_____

(STREET ADDRESS)

_____

(CITY/STATE/ZIP CODE)

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact commits a fraudulent insurance act, which is a crime.

CERTIFICATE OF SERVICE

I certify that the original was mailed to the Department of Workers Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 and copies of this motion and attachments were mailed to the names and addresses of the parties given below:

Attorney for Employer or Insurance Carrier _____
if applicable: **(Name)**

_____
(**Street Address)**

_____
(City/State/Zip)

Employer or Insurance Carrier: _____
(Name)

_____
(Street Address)

_____
(City/State/Zip)

Other Parties, if applicable: _____
(Name)

_____
(Street Address)

_____
(City/State/Zip)

Special Fund, if applicable: _____
(Special Fund)

_____

(Street Address)

_____

(City/State/Zip)

This _____ day of _____, 20___.

_____

(Employee's Signature)